Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHEAST METHODIST HOSPITAL
3701 KIRBY DR
STE 1288
HOUSTON TX 77098-3916

Respondent Name
Montgomery Ward/TCSIGA

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-1826-01

MFDR Date Received
January 30, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated January 27, 2012: "The fees paid by the Carrier in this case do not conform to the reimbursement section of Rule § 134.403. …it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case."

Amount in Dispute: $6,098.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 10, 2012: "The carrier has priced the bills for date of service 2/22/11 numerous times, utilizing the Texas Fee Guidelines for outpatient hospital services. Carrier contends that no further reimbursement is owed for the services provided."

Response Submitted by: Parker & Associates, L.L.C. 7600 Chevy Chase Dr. Suite 350, Austin, TX 78752

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2011	Outpatient Hospital Services	$6,098.13	$5,522.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 25, 2011

- 595-003 REIMBURSEMENT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE STATE SPECIFIED PERCENTAGE INCREASE AND IMPLANTABLE CARVE OUT
- 595-004 THE ALLOWANCE FOR THIS LINE HAS BEEN SUMMED WITH OTHER ALLOWANCES ON THE BILL AND RE-DISTRIBUTED EVENLY.
- 670-007 REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.

Explanation of benefits dated August 1, 2011

- 999 $105,726.12 OF THE CHARGES ARE DUPLICATES OF BILL # 21-U-733-0

Explanation of benefits dated August 23, 2011

- 595-003 REIMBURSEMENT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE STATE SPECIFIED PERCENTAGE INCREASE AND IMPLANTABLE CARVE OUT.
- 595-004 THE ALLOWANCE FOR THIS LINE HAS BEEN SUMMED WITH OTHER ALLOWANCES ON THE BILL AND RE-DISTRIBUTED EVENLY.
- 670-007 REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES
- 901 RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Explanation of benefits dated December 19, 2011

- 595-003 REIMBURSEMENT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE STATE SPECIFIED PERCENTAGE INCREASE AND IMPLANTABLE CARVE OUT.
- 595-004 THE ALLOWANCE FOR THIS LINE HAS BEEN SUMMED WITH OTHER ALLOWANCES ON THE BILL AND RE-DISTRIBUTED EVENLY.
- 670-007 REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES
- 901 RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $94,633.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an

Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code C1820, date of service February 22, 2011, represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code C1778, date of service February 22, 2011, represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code 80051, date of service February 22, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.87. 125% of this amount is $12.34. The recommended payment is $12.34.
- Procedure code 85027, date of service February 22, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.11. 125% of this amount is $11.39. The recommended payment is $11.39.
- Procedure code 85610, date of service February 22, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.53. 125% of this amount is $6.91. The recommended payment is $6.91.
- Procedure code 85730, date of service February 22, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.45. 125% of this amount is $10.56. The recommended payment is $10.56.
- Procedure code 71010, date of service February 22, 2011, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this ancillary procedure code is packaged when reported on the same claim as the critical care evaluation and management code 99291; however, this service does not meet the criteria for critical care packaging. This line is not assigned to a composite APC and may be paid separately. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.02. This amount multiplied by the annual wage index for this facility of 0.903 yields an adjusted labor-related amount of $24.40. The non-labor related portion is 40% of the APC rate or $18.02. The sum of the labor and non-labor related amounts is $42.42. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $42.42. This amount multiplied by 130% yields a MAR of $55.15.
- Procedure code 63685, date of service February 22, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC

payment. These services are classified under APC 0039, which, per OPPS Addendum A, has a payment rate of $14,743.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $8,846.15. This amount multiplied by the annual wage index for this facility of 0.903 yields an adjusted labor-related amount of $7,988.07. The non-labor related portion is 40% of the APC rate or $5,897.43. The sum of the labor and non-labor related amounts is $13,885.50. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $13,885.50 divided by the sum of all S and T APC payments of $18,199.20 gives an APC payment ratio for this line of 0.762973, multiplied by the sum of all S and T line charges of $6,169.00, yields a new charge amount of $4,706.78 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.203. This ratio multiplied by the billed charge of $4,706.78 yields a cost of $955.48. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $13,885.50 divided by the sum of all APC payments is 76.12%. The sum of all packaged costs is $20,010.15. The allocated portion of packaged costs is $15,231.70. This amount added to the service cost yields a total cost of $16,187.18. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $13,885.50. This amount multiplied by 130% yields a MAR of $18,051.15.

- Procedure code 63650, date of service February 22, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,553.02. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,731.81. This amount multiplied by the annual wage index for this facility of 0.903 yields an adjusted labor-related amount of $2,466.82. The non-labor related portion is 40% of the APC rate or $1,821.21. The sum of the labor and non-labor related amounts is $4,288.03. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $4,288.03 divided by the sum of all S and T APC payments of $18,199.20 gives an APC payment ratio for this line of 0.235616, multiplied by the sum of all S and T line charges of $6,169.00, yields a new charge amount of $1,453.52 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.203. This ratio multiplied by the billed charge of $1,453.52 yields a cost of $295.06. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $4,288.03 divided by the sum of all APC payments is 23.51%. The sum of all packaged costs is $20,010.15. The allocated portion of packaged costs is $4,703.76. This amount added to the service cost yields a total cost of $4,998.82. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $4,288.03. This amount multiplied by 130% yields a MAR of $5,574.44.
- Per Medicare policy, procedure code 93005, date of service February 22, 2011, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

4. Review of the submitted documentation finds that the separate implantables include: "Generator IPG SC1110" as identified in the itemized statement and labeled on the invoice as "PRECISION IPG KIT DUAL ARRAY" with a cost per unit of $15,405.75; "LEAD PULSE GENERATR 70" as identified in the itemized statement and labeled on the invoice as "ENH ST LD KIT, SC-2218-70 8 " with a cost per unit of $1,792.50 at 2 units, for a

total cost of $3,585.00. The total net invoice amount (exclusive of rebates and discounts) is $18,990.75. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,358.50. The total recommended reimbursement amount for the implantable items is $20,349.25.

5. The total allowable reimbursement for the services in dispute is $44,071.19. This amount less the amount previously paid by the insurance carrier of $38,548.66 leaves an amount due to the requestor of $5,522.53. This amount is recommended.

Conclusion

For the reasons state above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is 5,522.53.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,522.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		February 22, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.